Attachment E.I.c.
to Family Care Waiver
Application Pre-Print

Section E:
Fraud and Abuse

Fraud Prevention
and Detection Plan

Department of Health and Family Services
Family Care Fraud Prevention and Detection Plan

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The Department of Health and Family Services (the department) believes that the new Family Care benefit will improve the system of LTC services and supports that are needed by the frail elderly and people with disabilities while expanding access and choice. Nevertheless, with the introduction of new payment mechanisms, the department must be vigilant in ensuring that opportunities for fraud and abuse do not follow. The department's program takes a proactive approach to stopping the potential for fraud and abuse before it happens. It will do this by focusing its resources on early detection of problems and potentially abusive patterns.

Fraud in Managed Care

Capitation and prospective risk-sharing payment arrangements, of which Wisconsin's Family Care LTC benefit is one, contain different economic incentives than fee for service arrangements. As a result, new and different opportunities for fraud[1] and abuse are presented. Specifically, prospective payment arrangements shift the financial risk for the overuse of health care services to the contracted managed care organization. This means that for Care Management Organizations (CMO), fewer dollars spent on services will translate to increased financial gain for the organization.

To illustrate further, CMOs will receive a fixed monthly prospective per member payment for each member enrolled and in return must provide or arrange for the provision of all LTC services that are needed by the enrollee. If the CMO spends less than the monthly amount, the organization's short-term profits are maximized. On the flip side, the CMO incurs a loss if the cost of furnishing the services exceeds payment under the contract. Thus, it is easy to see how prospective payment arrangements can influence the delivery of health care and, consequently, have the potential to affect the lives of members. For this reason, it is important to address both the quantity of services provided by the CMO and to continually monitor the quality of the care and services provided to Medicaid recipients and other Wisconsin citizens who are enrolled in CMOs. Wisconsin's Family Care fraud prevention and detection plan reflects these different incentives.

Approach to Preventing Fraud and Abuse in Family Care

Wisconsin's fraud prevention and detection plan for Family Care is primarily concerned with ensuring that the full array of high quality Family Care services are available from the CMO or its contracted providers and that needed services are actually delivered. The department will provide this assurance by encouraging each CMO to voluntarily establish a strong internal compliance program. This emphasis on internal compliance represents a fundamentally different approach from traditional fraud detection plans. Rather than the state policing the contractor, the contractor is a full partner and as such continually monitors its own internal operations and its relationships with subcontractors. This

[1] The National Health Care Anti-Fraud Association defines fraud as "an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party."

results in, rather than an adversarial relationship between the state and the CMO, a relationship of cooperation and mutual support. CMO providers also benefit because a successful compliance program helps them to avoid potential civil and criminal liability.

The Family Care fraud prevention and detection plan uses a two pronged approach. First, is to foster efforts within the CMO to develop effective and efficient operational capabilities to guard against fraud and abuse, and provide guidance so that each CMO can comply with contract requirements. Second, is to implement systematic processes for detecting and documenting alleged violations and formally notifying the proper authorities of such instances. This paper identifies the systems and resources that are devoted to this effort.

Program Resources and Elements

Wisconsin is committed to the successful implementation of Family Care, which includes the prevention and detection of fraud and abuse. The Department of Health and Family Services' (the department) is the state agency that is responsible for implementing the plan for detecting and preventing fraud in Family Care. The responsibility for carrying out the activities described in this plan lies within the department's Office of Strategic Finance (OSF) and the Office of Program Review and Audit.

For the duration of the initial Family Care waiver period, the planning, implementing and monitoring of the Family Care fraud prevention and detection plan, including the review of all documents and other information that are relevant to compliance activities, will be carried out by Center for Delivery System Development (a sub-unit of OSF) in collaboration with other department divisions. An intradepartmental workgroup may be established to assist in the implementation of the compliance program. If established, the workgroup will work with appropriate divisions to develop standards, polices and procedures that will assist with the work of carrying out the compliance program. Furthermore, all individuals involved in compliance monitoring will be trained on the policies, procedures and methods of the program.

The department's approach to preventing and detecting fraud and abuse in Family Care includes the following elements:

1. Promote the development of effective controls that are internal to the CMO and which promote adherence to Family Care program requirements and relevant state and federal statutes and regulations in the following risk areas: marketing plan and materials, underutilization, quality assurance and quality improvement, accessibility of Family Care services and providers, and subcontracting arrangements;
2. Conduct precontract monitoring of CMOs through precertification reviews of written standards, policies and procedures that address the potential areas of risk, using effective tools that accurately assess CMO operations and its ability to implement Family Care;

3. Continually assess the adequacy of resources the CMO devotes to implementing Family Care, such as for effective education and training programs for employees and providers;
4. During the initial implementation phase, analyze the effectiveness of the CMO's lines of communication between employees, providers and members, especially in regard to member services and receiving complaints and grievances;
5. The use of evaluation techniques such as audits to monitor compliance and provide technical assistance to address weaknesses and strengthen areas where problems may be developing;
6. The development of policies to respond to detected noncompliance issues and initiate corrective action to prevent similar issues from occurring; and
7. The development of mechanisms that facilitate prompt, thorough investigations of possible misconduct by CMOs.

CMO Control Mechanisms

The CMO maintains the ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the state. As part of its responsibility for compliance, each CMO must develop written policies and procedures that address specific areas that are vulnerable to fraudulent behavior. Included among these risk areas are marketing plans and marketing materials, disenrollment, utilization management policies, quality of care and services, access to services, and underutilization.

CMO Marketing Plan and Materials

Because of the nature of managed care arrangements, the marketing process is a risk area for fraud and abuse. Discrimination in the marketing and enrollment processes may have the effect of denying or discouraging enrollment by eligible individuals.

While CMOs are prohibited from conducting direct cold calls to market enrollment in the CMO, they are not prohibited from indirect marketing activities, such as marketing at health fairs and contacting in person, potential enrollees who request further information about the CMO. In addition, certain types of practices on the part of the CMO, like asking a potential member probing medical questions prior to enrollment, are prohibited. Each CMO must implement policies to ensure that inappropriate behavior on the part of CMO employees does not occur during contacts with potential enrollees.

As a condition if its contract with the state, each CMO must submit to the department, it's marketing plan for the contract period. The CMO must assure that its plan does not attempt to target healthier individuals by marketing the CMO only in places where healthier enrollees would be more likely to be present. Furthermore, CMOs must take special care to ensure that all marketing materials are complete and accurate and include information about the limits on choice of providers and rules for authorization of services.

Accurate and useful information is crucial to the success of Family Care. CMOs must correctly and completely describe essential information in any marketing materials and

other materials distributed to individuals once enrolled in the CMO. CMOs must carefully scrutinize all CMO marketing materials to assure they meet with state guidelines.

Disenrollment from the CMO

CMOs are prohibited from disenrolling or requesting or encouraging an individual to disenroll from Family Care. Each CMO must implement policies to ensure that inappropriate disenrollment does not occur and train its staff and providers when it is appropriate for staff or providers to discuss the concept of disenrollment with a member. For instance, a CMO staff person should probably never initiate a discussion about disenrollment and should never promote disenrollment.

Quality Assurance and Quality Improvement

CMOs must have an ongoing quality assurance and quality improvement (QA/QI) program for the services it furnishes to its enrollees. The internal QA/QI program description may be found in the department's prepaid health plan (PHP) contract for CMOs. Prior to becoming a certified CMO, each entity must submit and gain approval of a QA/QI workplan for the ensuing contract period.

Utilization Management

Some CMOs may try to control costs through legitimate techniques such as imposing appropriate limits on access to certain health care services (e.g., utilization review and restricting provider networks) and negotiating discounts on health care services and equipment. These techniques, however, when used improperly, give rise to liability for health care fraud and abuse and the potential for enforcement actions to be taken.

As described earlier in this paper, the incentives to provide unnecessary services dissolve in a managed care environment. Therefore, utilization management mechanisms are vastly different in Family Care than in Medicaid fee for service. CMOs are required to follow written policies and procedures when processing requests for initial or continued authorization of services in the Family Care benefit. The department must approve all criteria a CMO uses to limit or deny services through a prior or continuing authorization process. CMOs must also have adequate systems in place to monitor service authorization policies for inappropriate denials.

Underutilization

Family Care CMOs must ensure that all covered services are available and accessible to all enrollees. The state views the inappropriate withholding or delay of services, know as underutilization, as a serious concern. Examples of practices that can lead to underutilization and poor quality include the failure to contract with sufficient providers to meet the needs of all enrollees, the failure to provide geographically reachable services, the delay in approving or failure to approve referrals for covered services, burdensome utilization review procedures, and inappropriate denial of payment all of which are prohibited actions under the contract.

To safeguard against inappropriate practices, which may lead to underutilization and result in financial gain to the CMO, CMOs will be expected to find effective ways to

track the utilization of services to detect potential fraudulent practices. The methods a CMO may use include collecting data on utilization patterns and detecting aberrant patterns. The department may check these data against utilization rates for service before implementing Family Care and expected utilization after Family Care.

Continual Monitoring of Access to Services

The department requires the CMO to establish mechanisms to ensure access and availability of Family Care benefit plan services. To meet this requirement, the CMO must develop its own access and capacity standards and monitor continuously for compliance to its standards. It may accomplish this monitoring through the use of member surveys; analysis of member complaints and grievances; random test calls to its member services area; periodic audits; and requirements that providers provide regular reports on pre-established access standards and measures. The CMO's work in this area should evaluate access and availability for all services the organization is responsible for providing under its contract and take corrective action if there is failure to comply.

With this requirement, the CMO not only initiates a corrective action plan, but also includes a process for assessing the effectiveness of the corrective action. For example, if a problem of minimum compliance arises that applies to an entire service type or specialty, a potential corrective action might be that the CMO proposes to expand its facilities or provider network. If the problem involves a specific provider, the CMO might instead propose, as part of its corrective action, that it close off the provider to new enrollees or, in the alternative, monitor the provider. It must be emphasized here that the CMO should not aim toward merely complying with the department's minimum standards but rather promote its own continuous quality improvement above and beyond those minimum standards.

The department will monitor the CMO's compliance with these internal control requirements through analysis of complaints or grievances and annual grievance summary reports, member requests to change providers, CMO enrollee surveys, an analysis of reasons for disenrollment, and other sources of information. Issues in compliance will be addressed through education or technical assistance of the CMO staff or providers or other corrective action, and information on compliance with the policies is be considered during the contract renewal and CMO evaluation process.

Independent Audit of the CMO

Annually, each CMO is required to submit documentation of an external audit by an auditor who has expertise in Federal and State health care statutes, regulations and Federal and State health care program requirements. The audit should focus on the CMO's programs, including external relationships with third-party contractors. Additionally, it should cover the range of programmatic requirements of the Family Care program and comply with generally accepted protocols governing such audits. In particular, the audits should focus on financial issues, especially data and information that affect payments.

At a minimum, the audit report materials that a CMO sends to the department must include the following elements:

- The financial statements of the CMO and auditor's opinion on the financial statements of the CMO.
- The auditor's report on the CMO's compliance and internal controls based on the financial statement audit performed in accordance with *Government Auditing Standards.*
- Assurance that the audit was performed in accordance with the requirements of the *Family Care Audit Guide.* This assurance may be in the form of a separate report on compliance with the requirements of the *Family Care Audit Guide* or reference to the *Guide* in the report on internal controls and compliance that is required for the audit performed in accordance with *Government Auditing Standards.*
- The schedule of findings and questioned costs.
- The schedule of prior year findings.
- The management letter (or similar document conveying auditors' comments issued as a result of the audit) or written assurance a management letter was not issued as a result of the audit.
- The CMO's corrective action plan for all findings in the audit report and the management letter, if one was issued.

CMO Information Systems

The CMO is required to have the ability to collect, monitor, and analyze data for the purposes of financial management and quality assurance and improvement and to provide that data to the department in the manner required under the contract. Because of the increasing reliance on electronic data for managing and improving operations and services, the CMO must take particular care in establishing procedures for maintaining the integrity of data collection systems. This should include procedures for regularly backing-up data (either by diskette, restricted system or tape) collected in connection with all aspects of the Family Care program requirements. In addition, all CMOs should develop and implement policies and procedures to ensure the confidentiality and privacy of financial, medical, personnel and other sensitive information in their possession. These policies should address both electronic and hard copy documents.

Reporting Suspected Fraud and Abuse

Any entity seeking to contract as a CMO must have certain procedures in place for confidential reporting to the department information regarding alleged violations of state and federal laws and regulations. The CMO will be expected to implement procedures that allow the prompt, thorough investigation of possible misconduct by CMO managers, employees and subcontractors. Furthermore, procedures will be necessary for documenting alleged violations and formally notifying the department of such instances. Examples of potential fraud and abuse situations that should be reported to the state are:

1. Billing for services not rendered;
2. Billing for services not medically necessary;
3. Double billing for services provided;
4. Upcoding (e.g., billing for a more highly reimbursed service or product than the one provided);
5. Unbundling (e.g., billing separately for groups of laboratory tests performed together in order to get a higher reimbursement); and
6. Fraudulent cost reporting by institutional providers.

A CMO's failure to report potential or suspected fraud or abuse may result in sanctions, contract cancellation, or exclusion from participation in the Medicaid program.

Access to CMO Records

CMOs must establish policies and procedures regarding the creation, distribution, retention, storage, retrieval and destruction of documents. In addition, the CMO must have policies in place to inform its providers that, both the state and the CMO, have the authority to review, and/or obtain copies of service records of CMO members for quality review purposes or investigations of fraud/abuse.

State Control Mechanisms

The department is trying to be a better purchaser of LTC services by addressing fraud and abuse issues up front and by contracting only with CMOs that meet its standards for participation in Family Care. Proper contracting provisions, quality assurance mechanisms, and audits will be in place to ensure that CMOs comply with Family Care requirements and are accountable for their activities. To increase the likelihood of early identification and prevention of fraud and abuse, the department's CMO monitoring and enforcement activities will target the specific risk areas identified previously in this document.

Precertification Reviews

Precertification review activities are those that occur before the department enters into a contract with an entity. The information that is submitted by the CMO during the Family Care precertification review should provide assurance that the CMO can meet performance and financial standards of Family Care before the contract period begins.

Recognizing that managed care fraud and abuse can take many forms; the state reviews, prospectively, written CMO policies, standards and practices in a number of risk areas. Each CMO, as part of the precertification process, must submit extensive documentation to the state in the following areas: marketing practices and member informing materials, complaints and grievance procedures, safety and risk related to safety, quality assurance and improvement including resources dedicated to the QA/QI program, authorization policies, provider network standards and provider contracts, and enrollee rights. All required standards, policies and procedures are submitted to the state at least six weeks before the CMO's scheduled date of contract signing.

State staff review written policies and procedures to determine whether the CMO has articulated correctly specific procedures that should be followed by employees and providers in the fraud and abuse risk areas. Reviewers use objective criteria to determine if all applicable contract requirements, statutes, and rules have been addressed and whether specific procedures correctly state how CMO personnel should carry out the performance of their duties. For example, reviewers examine CMO subcontracts and payment arrangements to ensure that there are no provisions that may adversely effect the quality of care. Another example is the checking of the geographic locations of providers to ensure that members are not required to travel extensively to receive services. In verifying that policies and procedures meet all requirements, reviewers ensure that

procedures are adequate, are based on the contract, and describe how they will be implemented.

A CMO is awarded a contract on the basis of the responses and representations contained in its precertification materials. All responses and representations submitted by the CMO to which the criteria for precertification were based were considered material to the decision of whether to certify the entity as a Family Care CMO. Discovery of any material misrepresentation on the part of the CMO in the CMO's precertification materials or in the CMO's day-today activities and operations may be cause for taking action against the CMO under the contract.

Reviewing CMO Marketing Plans and Materials

In addition to the submission of policies and procedures, the CMO must submit its marketing plan and all enrollee-informing materials, such as member handbooks, for department approval. Department staff scrutinize these materials to assure that marketing plans, procedures, and materials are accurate and do not mislead, confuse, or defraud members, potential members or the Medicaid program. Examples of misleading marketing information would be an assertion that the recipient must enroll with the CMO to get *any* Medicaid benefits, or that the CMO is recommended or endorsed by the state.

Reviewing CMO QA/QI Programs and Workplan

Each CMO must have a written description of its QA/QI program description that addresses QA/QI leadership and both quality assurance activities and quality improvement activities and includes a workplan for implementing the program. The CMO's annual QA/QI workplan must include objectives and a timetable for achieving the objectives. Each performance improvement project and other interventions to be implemented over a prescribed period of time to achieve improvement are described in a detailed QA/QI workplan. Department staff reviews and approves each CMO's QA/QI workplan prior to the initial contract period.

Reviewing CMO Service Authorization Policies

The PHP contract allows CMOs to require that members obtain prior authorization of certain services even though the member’s interdisciplinary team recommends the services. However, prior authorization requirements must not be applied arbitrarily. To ensure appropriate and prompt access to all services in the Family Care benefit package, the CMO must have documented policies and procedures for determining approval or denial of services. These policies require review and approval by the department before the initial contract period and must be communicated to members by placing them in the CMO member handbook.

CMO Provider Network Adequacy

Certification to be a CMO requires each entity to demonstrate that it has adequate availability of providers to meet the preferences and needs of potential enrolled members. To meet the requirements of the Family Care statute, the CMO applicant must submit documentation of its capacity to assure timely provision of Family Care services to the expected enrollment in the CMO’s service area. As part of the documentation, the CMO must show that it is not merely creating a situation where members are steered to existing residential slots, but are instead treated as individuals whose preferences are honored.

Such documentation may be in the form of written agreements with providers who are available to provide all LTC services in the Family Care benefit in sufficient quantity to meet the needs of the potential enrolled membership or a description of how the CMO plans to provide the service directly to the expected enrollment.

The department will review each CMO's documentation and conduct any necessary reviews to determine if the CMO has adequate capacity to serve the expected enrollment. In the future, local LTC councils, which will have 51% consumer representation, will also review relevant documents and make recommendations to the department on whether or not the applicant meets certification requirements. If the requirements for certification are not fully met, the department may conditionally approve the CMO to operate. In this circumstance, approval will be contingent upon the CMO meeting specified conditions that must be met before full certification is granted.

Ongoing CMO Monitoring and Oversight

An ongoing evaluation process is critical to a successful fraud prevention and detection program. The department will use a variety of different methods as it monitors and evaluates the ongoing operations of the CMO. In general, techniques such as on-site audits, questionnaires (for providers, enrollees and employees), and trend analyses will be used , which will cover a range of program requirements. In particular, monitoring activities will focus on the risk areas identified earlier in this document and any areas of specific concern identified within a CMO or those that may have been identified by any outside agency.

Monitoring techniques will incorporate periodic (at a minimum, annual) reviews of whether the CMO has satisfied required program elements, e.g, whether there has been appropriate dissemination of the CMO's standards, policies and procedures in the risk areas and whether or not employees and providers have been trained on its standards and protocols. This process will verify actual conformance by the CMO with its own policies and procedures related to compliance with the PHP contract.

Such reviews may support a determination that appropriate records have been created and maintained to document the implementation of an effective program. If department reviewers determine that nonconformance has occurred for legitimate, explainable reasons, corrective action may be limited or no corrective action may be taken. If department reviewers determine that the nonconformance to CMO standards, policies and procedures was caused by improper procedures, misunderstanding of rules, including fraud and systemic problems, the CMO will be required to take prompt steps to correct the problem.

Monitoring CMO Marketing Practices

Periodically, the department will evaluate CMO compliance to marketing and disenrollment functions. It may use methods such a surveying current enrollees and former enrollees and spot checking marketing materials, such as brochures, leaflets, newspapers and CMO communications to providers. Other methods that may be used to monitor the marketing practices of the CMO include the analysis of disenrollment data to identify high and low percentages of member disenrollments within a set number of days

(e.g., 90 days). In addition, the department may survey CMO members to verify that they understand the choice restrictions of the CMO or its service authorization policies. And finally, the department will review CMO marketing materials to ensure that they do not mislead, confuse or misrepresent any aspect of Family Care and that they are consistent with the policies, procedures and practices of the CMO.

Monitoring Access to Services

The state plans to periodically review the composition of the CMO's provider network and match the geographic location of its providers against the CMO's service area to ensure adequate access to services. In reviewing provider networks, the state will collect data on the number of provider types in the service area and whether or not the numbers and types have changed since the precontract review. The state will also review CMO member complaints and grievances to detect if access to services is being inappropriately denied. See Attachment B. on Access and Capacity and Attachment C. I. on the State's Quality Strategy for a complete description of how the state will monitor access and capacity in Family Care.

Monitoring CMO Provider Selection

CMOs are required to have a local process to assure that persons providing services and/or supports are trained and qualified to perform their duties. The department is particularly concerned that the CMO have procedures for the selection of providers which includes an application, verification of information and a site visit if applicable. These procedures will ensure that members are receiving Family Care services from providers that are appropriately licensed, have the appropriate expertise and are in compliance with all state and federal laws. The CMO must also verify that any subcontracted provider meets pre-set CMO specific standards and must report to the department whenever a subcontract is terminated because of quality problems with a provider.

Annually, department staff will interview CMO staff and providers and review CMO documentation to determine if the CMO is adhering to its policies and procedures in this area. The department may also conduct a survey of CMO subcontracted providers in order to assess CMO performance from the provider's perspective.

Monitoring Utilization

Tracking utilization data will be vital to the state's compliance control plan. Comparing CMO service utilization data, obtained from review of encounter data and service plan reviews, with data on services provided before the waiver under both the Medicaid fee-for-service program and the home and community based waiver programs will be an essential part of the state's strategy. Referral patterns and types of appeals and grievances received will also be tracked. The department may also survey current CMO enrollees and disenrolled enrollees on utilization patterns and whether CMO members felt they were subjected to inadequate services or inappropriate denials.

Monitoring Quality

Elements of the state's quality strategy for Family Care include: (1) contract provisions that incorporate standards for access and availability of services, including timeliness of services, provider networks, and measurement and improvement; (2) procedures for assessing the quality and appropriateness of care and services furnished to all Medicaid

enrollees under the Family Care contract, including, but not limited to, continuous monitoring and evaluation of CMO compliance with the standards. (For a full description of the state's quality strategy see the paper titled "Family Care CMO Quality Monitoring and Oversight Plan", Attachment C.I.a.)

CMO Subcontracts

The CMO is required to obtain department approval for all subcontracts with service providers, and the department may impose conditions or limitations on its approval of subcontracts. All contracts with service providers must be in writing and include the provisions specified by the department. The department will conduct an audit of each CMO to determine whether the CMO obtained department approval for all subcontracts with service providers and that it has complied with any conditions or limitations, which the department imposed on its approval of the subcontracts.

Performance of service providers

The CMO is required to monitor and evaluate each service provider's performance on an on-going basis and to perform a formal review at least once a year. The CMO may accomplish this by obtaining member input on the quality of providers, reviewing complaints and grievance reports, and analyzing performance measures and other information on providers. The department will conduct an audit to determine whether the CMO:

- Maintained an accurate and complete list of its service providers.
- Ensured that the service provider complied with all of the terms and conditions of the contract.
- Required financial, performance, program, and special reports from service providers; reviewed them in a timely manner; and took action when problems were noted.
- Had an effective means of monitoring the service provider, including collecting and reviewing audit reports in a timely manner, and took action when problems were noted.
- Performed a formal review of each service provider at least once a year.
- Ensured that monitoring staff had skills to effectively monitor subcontracts.

Monitoring CMO Individualized Service Plans (ISPs)

The CMO is required to develop and implement an ISP for each CMO member within contractually required timeframes. For a sample of member service plans, the department will conduct a review, which will consist of reviewing available information about services, supports, time frames, and staff responsible for service provision. The purpose of the review is to determine how well the CMO is using the assessment and planning process to coordinate supports for the individual and whether or not the CMO is writing service plan goals that reflect the individual's stated desires and preferences. (For a full description of the state's strategy for reviewing CMO member service plans see the paper titled "Family Care CMO Quality Monitoring and Oversight Plan", Attachment C.I.a.)

Monitoring of CMO Business Practices

Payments to Service Providers

The CMO is required to have a claims retrieval system which can identify the date service was received, the action taken on all provider claims (i.e. paid, denied, other), and the date the action was taken. The CMO is also required to date stamp all provider claims upon receipt and to pay at least 90% of claims from service providers for services in the long term care benefit package that receive advance authorization from the CMO within 30 days of receipt of the bill, and 99% within 90 days, except to the extent service providers have agreed to later payment. The department will conduct a review to determine whether the CMO's claims system can identify the date service was received, the action taken on all claims, and the date the action was taken; that claims submitted to the CMO from service providers are date stamped upon receipt; and that CMO paid claims from subcontractors within the required timeframe.

Conflict of Interest

The CMO must disclose certain business transactions between it and any parties in interest, i.e., any person directly or indirectly controlling, controlled by, or under common control with the CMO. The department will conduct an audit to determine whether the CMO has had prohibited transactions with parties in interest which meet the definition for transactions which must be disclosed to the department.

Solvency Protection

The CMO is required to provide solvency protection through a cash reserve and any other means acceptable to the department, including aggregate reinsurance, lines of credit, or parent guarantees. The minimum balance for the cash reserve account is 15% of the projected CMO revenue for the term of the contract period, adjusted to 15% of actual CMO revenue within 45 days following the independent audit for that contract period. CMO revenue is all payments made by the department to the CMO to provide services in the long term care benefit package to its members.

The cash reserve is to be kept in a separate depository or investment account so that it is not intermingled with other funds. Contributions to and disbursements from the cash reserve account are to be clearly identifiable within the accounting system and supported by documentation.

The CMO may make disbursements from the reserve account to fund payments to the department under risk sharing, fee-for-service savings, and excess cost reimbursement or to fund operating deficits. If the balance in the cash reserve account falls below the minimum balance, the CMO is required to notify the department within 10 days. In addition, if the CMO withdraws $10,000 or more in aggregate during any quarter, the CMO is required to notify the department no later than 45 days after the aggregate disbursement.

The department will conduct an audit to determine whether:

- CMO's method of projecting CMO revenue is reasonable;
- The CMO maintained the required level of cash reserve.

- The CMO's cash reserve account was kept separate from other funds and deposits and withdrawals were clearly identified in the accounting system.
- The CMO met the department's reporting requirements for disbursements from the cash reserve account.

CMO Information Systems

The CMO is required to have the ability to collect, monitor, and analyze data for the purposes of financial management and quality assurance and improvement and to provide that data to the department in the manner required under the contract. At a minimum, the CMO's system is required to include:

- Systems to ensure that information used for financial management and reporting purposes is timely, accurate, and complete.
- An accounting system that meets the business needs of a managed care organization.
- Polices and procedures to promote effective cost control.
- Policies and procedures to accumulate and appropriately utilize the solvency protections as specified in the contract.

The department will conduct audits to determine whether the CMO's information system meets department's requirements for such a system.

Required CMO Reports

The CMO is required to submit reports that cover the entire range of requirements with which a CMO must comply, the specifics of which are too detailed to enumerate in this document. The CMO must also meet all of the reporting requirements as specified in the contract in a timely way, assure the accuracy and completeness of the data, and submit the reports/data in a timely manner. The CMO's records must support data submitted to the department. The department will conduct audit procedures that will, for a sample of reports prepared by the CMO, and submitted to the department:

- Review the instructions for completing the reports.
- Perform analytical procedures and determine the reason for any unexpected differences. The results of the analytical procedures should be considered in determining the nature, timing, and extent of the other audit procedures for reporting.
- Trace the data to records that accumulate and summarize data.
- Perform tests of the underlying data to verify that the data were accumulated and summarized in accordance with the required or stated criteria and methodology, including the accuracy and completeness of the reports.
- Test mathematical accuracy of reports and supporting worksheets.
- Review accounting records and determine whether all applicable data elements or accounts (e.g., program income, expenditure credits, loans, interest earned on department funds, and reserve funds) were included in the sampled reports.

Communication Methods

Because the CMO serves as an intermediary between the provider and the CMO member, communication and coordination functions of the department's fraud prevention and detection plan serves a critical role. The department will implement methods to encourage communication among all parties, CMOs, subcontracted providers, and members. For example, as appropriate, it will communicate the results of audits,

disenrollment surveys, utilization data and quality of care determinations to CMOs in order to facilitate open discussion regarding contract requirements and appropriate service delivery. It will also issue contract interpretation bulletins (CIB) to facilitate and promote the CMO's commitment to compliance and that address specific areas of risk.

Family Care Hotline

Family Care enrollees, CMO employees or other parties can report potential violations of Family Care program requirements, suspected fraud, waste or abuse via a dedicated phone line. The telephone number of the hotline is made available by conspicuously posting and circulating the number in common, public sites. A log will be maintained that records such calls, including subsequent investigations and the results of investigations. Anyone calling the hotline may remain anonymous.

Outreach

Outreach efforts will also focus on CMO enrollees and their family members and guardians, educating them on how to recognize and report suspected fraud and abuse. Consumers of services can be the first line of defense against fraud. The Department places a high priority on this kind of outreach and intends to increase its efforts to enhance public awareness of fraud and abuse risk areas in managed care.

Enforcement Actions for Noncompliance and Fraud

A range of possible enforcement actions is available to the department when noncompliance to contractual requirements is discovered. These include oral warnings to suspension, termination or other sanctions, as appropriate. Each situation will be considered on a case-by-case basis to determine the appropriate sanction.

When either the department or the CMO finds evidence of misconduct, the department will refer the evidence to our own internal corrective system and will refer all potential fraud and abuse cases through appropriate channels. While it is not the department’s or the CMO’s responsibility to determine whether fraud has actually occurred, certain types of activities clearly fall into the category of fraud and abuse. Intentional or reckless noncompliance may subject violators to significant sanctions. Some examples of managed care fraud and abuse that, if substantiated, will be subject to sanctions follow:

- A systemic effort to move high risk CMO enrollees out of the CMO ("disenrollment fraud")
- "Cherry-picking" or recruitment of healthier-than-average enrollees through improper screening ("enrollment fraud");
- Misrepresentations of information in member marketing or other materials regarding:
  - Quality of healthcare services or benefits;
  - Qualifications of participating providers or the size or composition of provider networks;
  - Access to Family Care services;
- Misrepresentations in "encounter data" or other data submitted to the state and utilized to determine capitation rates;
- Systematic denials of promised treatment or benefits or systematic delays in providing treatment or benefit information;

- Payment arrangements with providers and claims administrators that promote fraudulent underutilization; and
- Improper beneficiary inducements to enrollment.

Conclusion

The Family Care statute, Family Care regulations and the PHP contract provide a clear basis for Family Care monitoring activities. The department will develop monitoring tools, guidelines, procedures, and data systems that target the risk areas most vulnerable to managed care fraud and abuse. The department's Family Care fraud prevention and detection plan addresses the major areas of concern with managed care contracting and describes a strategy which ensures that CMO member protections are maintained and traditional financial safeguards are in place. Thus, the department's monitoring and enforcement efforts for preventing fraud and abuse in Family Care before it happens are enhanced and the department is in a position to be responsive to the expansion of managed care into Wisconsin's LTC programs.